COMMONWEALTH OF VIRGINIA
Department of Health

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STATE HEALTH COMMISSIONER

OFFICE OF ADJUDICATION

DOUGLAS R. HARRIS, J.D.

RECOMMENDATION TO THE STATE HEALTH COMMISSIONER REGARDING CERTIFICATE OF PUBLIC NEED (COPN)

REQUEST NUMBER VA-6532
BON SECOUR HAMPTON ROADS HEALTH SYSTEMS, INC., and CHILDREN'S HOSPITAL OF THE KING'S DAUGHTERS
Establishment of an Outpatient Surgical Hospital in Virginia Beach

and

REQUEST NUMBER VA-6527
SENTARA VIRGINIA BEACH GENERAL HOSPITAL
Addition of Operating Rooms in Virginia Beach

I. FINDINGS OF FACT

A. Introduction

1. In January 2001, Bon Secours DePaul Medical Center (DePaul), located in the City of Norfolk, and Sentara Virginia Beach General Hospital (Virginia Beach General), in the City of Virginia Beach, applied for certificates of public need (COPNs) in accordance with the "structured batching process" authorized by law, seeking authorization to establish or add operating room capacity in planning district (PD 20), located within Health Planning Region V (HPR V), also known as the Eastern Virginia Health Planning Region.

2. The Eastern Virginia Health Systems Agency (EVHSA) serves HPR V by reviewing "projects," as defined in Section 32.1-102.1 of the Virginia Code, proposed for location within the boundaries of the planning region.

3. DePaul seeks authority to relocate through construction four operating rooms (ORs) from the hospital to Virginia Beach, specifically, by establishing an outpatient surgical hospital (OSH), on land owned by the Bon Secours Hampton Roads Health System, Inc., at the intersection of Princess Ann

Road and South Plaza Trail. DePaul currently has 10 general purpose ORs. In 1999, DePaul's ORs operated at 57.9 percent of the 1,600 hour-per-year standard contained in the State Medical Facilities Plan (SMFP; 12 VAC 5-230 et seq.).

4. Virginia Beach General seeks authority to add through construction two general purpose ORs to the main surgical suite at the hospital. Virginia Beach General currently has nine ORs. In 1999, Virginia Beach General's ORs operated at 132.7 percent of the 1,600-hour standard.

5. Because these two applications were filed in the same "batch," or review cycle, and since they propose the same or similar services and facilities in the same planning district, they are "competing applications," as defined in 12 VAC 5-220-10, and must be reviewed comparatively.

6. DePaul is a 366-bed, not-for-profit, acute care general hospital located in the city of Norfolk, Virginia. DePaul is part of Bon Secours Hampton Roads Health System, Inc., which is a subsidiary of Bon Secours Health System, Inc., with offices in Marriottsville, Maryland.

7. Virginia Beach General is a 274-bed, not-for-profit, acute care general hospital located in the city of Virginia Beach, Virginia. Virginia Beach General is also a Level Two trauma center and is part of Sentara Health System, Inc., with offices in Norfolk, Virginia.

8. At the public hearing held by EVHSA on April 18, 2001 – almost three months after DePaul submitted its application to establish an OSH, it sought to amend its application to include Children's Hospital of the Kings Daughters (CHKD) as a co-applicant seeking the proposed OSH.

9. Upon request at the public hearing for clarification of this development and the arrangement involved, DePaul and CHKD did not describe with clarity the financial and organizational characteristics of their intended relationship or the parties' relative commitments as they would relate to the proposed OSH.

10. CHKD is a 178-bed, not-for-profit pediatric hospital located in the City of Norfolk, Virginia. Children's Health System, Inc., a non-stock, not-for-profit Virginia corporation, owns and operates CHKD. In 1999, CHKD's eight ORs operated at 69 percent of the 1,600-hour standard.

11. On April 23, 2001, Chesapeake General Hospital submitted a letter of opposition to the De-Paul-CHKD application. Chesapeake General received authorization to open a four-OR OSH in the service area targeted by DePaul for its proposed OSH; Chesapeake General opened its OSH on May 1, 2001.

12. All three of the applicants are, and both of proposed projects involved in this competitive review would be, located in planning district (PD) 20.

B. Factual and Regulatory Background

13. Parts I and II of Chapter 270 of the SMFP (12 VAC 5-270-10 et seq.) contain substantive provisions relating to the review of applications for COPNs authorizing projects that establish and add surgical services within a PD.

14. Since 1996, various applicants have proposed projects involving the establishment of OSHs in PD 20. The Commissioner approved two of these proposals. In 1997, Bon Secours-Maryview Medical Center, in the City of Portsmouth, received authority to establish an OSH in the City of Suffolk. Also in 1997, Chesapeake General Hospital in Chesapeake applied for authority to establish an OSH consisting of two ORs on the campus of the hospital; the Commissioner approved this project in April 1999 based on an adjudication officer's recommendation, and, in October 1999, approved its expansion to include a total of four ORs, as discussed below.

15. The adjudication officer's April 1999 recommendation for approval of Chesapeake General Hospital's project to establish an OSH, upon which the Commissioner relied, noted an absence of "substantive evidence of a public need to construct new [OSHs] in the Chesapeake and Virginia areas; however," he continued

> there is substantial and credible evidence that the [ORs] at Chesapeake General Hospital are approaching maximum use, and, if the patients and physicians who use [Chesapeake General] are to be accommodated in the future, additional [ORs] are needed.

In 1998 and 1999, the ten ORs at Chesapeake General operated in excess of 135 percent of the 1,600-hour standard.

16. In 1997, 1999 and 2000, the Bon Secours Hampton Roads Health System submitted applications proposing the establishment of an OSH in Virginia Beach. The Commissioner denied all three. These applications were similar to each other and to the present project proposed by DePaul – a Bon Secours facility, although the number of ORs sought by the Bon Secours system has varied from one to four.

17. The 1997 Bon Secours application proposed the relocation of four ORs from other hospitals. Also in 1997, the Sentara Health System proposed the establishment of an OSH by relocating three ORs from existing hospitals. The Commissioner denied both these applications, based on an adjudication officer's recommendation that found, in part, that "there is no justification from a 'public need' standpoint for establishing new outpatient surgical hospitals in Chesapeake or in Virginia Beach," and that

> [t]he basic intent of each of these proposals is to capture additional patients that are not now being served by either Sentara or Bon Secours . . . . These additional patients could be expected to come from the Chesapeake-Virginia Beach area. The facilities that currently serve this area, including [Chespapeake General Hospital], could be negatively affected by the addition of either or both of the proposed free-standing [OSHs], causing utilization to decrease and costs to increase.

18. In 1999, the Sentara Health System sought approval to establish three facilities: An ophthalmologic OSH, consisting of two ORs, in Virginia Beach; a general OSH, consisting of three ORs, in Chesapeake; and an OSH, consisting of three ORs, in Virginia Beach. The Commissioner denied all three of these applications. The latter proposal also formed the basis of an application submitted by the Sentara system in 2000; the Commissioner denied this application, also.

19. EVHSA recommended denial of all previous applications submitted by both the Bon Secours Hampton Health System and the Sentara Health System to establish OSHs in Virginia Beach.

20. Regarding the 2001 application from DePaul to establish an OSH in Virginia Beach – one of the present applications, the executive director of EVHSA stated that ". . . even though this time around CHKD has become associated with the project, virtually nothing has changed since 1997."

21. In 1998, the Bon Secours Hampton Health System and the Sentara Health System each attempted to "register" initiatives to establish OSHs that were basically similar to those proposed by each entity in 1997. The Commissioner denied these attempts to avoid review through creative interpretation. On appeal from Sentara, the Nineteenth Judicial Circuit of Virginia concluded that "the Commissioner did not err and, more specifically, agreed with the Commissioner's assertion that the proposals constituted efforts to "'establish[] . . . a medical care facility' under the statutory definition of 'project'."

22. In October 1999, the Commissioner approved a comprehensive expansion of Chesapeake General Hospital, which included specific approval to add a third and fourth OR to Chesapeake General's previously approved OSH. The adjudication officer's recommendation for approval of Chesapeake General's additional surgical capacity, upon which the Commissioner relied, noted the existence of "ample evidence of full utilization of the [ORs] at the Chesapeake General Hospital." Further, he wrote

> [t]here is ample evidence that additional surgical capacity is required at the site of [Chesapeake General] to justify the proposed two operating room addition. Although approval is contrary to the SMFP, it is apparent the addition of these two operating rooms is needed to provide surgical capacity relief *to a single community hospital* that is the most heavily used in the area. [Emphasis added.]

Chesapeake General Hospital's OSH opened on May 1, 2001, only a few minutes' drive from the site where DePaul-CHKD proposes to establish an OSH.

23. At an informal fact-finding conference (IFFC) held on June 6, 2001, to discuss the two present applications, the executive director of EVHSA noted that the April 1999 and October 1999 approvals of ORs at Chesapeake General's proposed OSH demonstrates that, although

> the SMFP contained no institutional need provision [at those times], . . . the Commissioner ha[s] consistently approved additional general purpose [ORs] at existing facilities when those facilities *had an institutional need* and when the [PD] also had an excess of [ORs]. [Emphasis added.]

24. In September 1999, the State Board of Health adopted emergency regulations specifically required by Virginia law enacted that year, *viz.*, Senate Bill 1282, and House Bills 2369 and 2543. Under Section 9-6.4:1 (C) (5) of the Virginia Code, emergency regulations may remain effective for a maximum of twelve months. The Board's 1999 emergency regulations, effective from January 3, 2000, to January 2, 2001, sought to amend the regulations governing the process by which the Department of Health reviews applications for COPNs and to amend the SMFP. Among other things,

the Board sought to implement an amendment of 12 VAC 5-230-270 A, which addresses the need for operating room capacity. In that section, the Board's emergency regulation codified the consideration of

> the addition of operating rooms by existing medical care facilities in planning districts with an excess supply of operating rooms . . . when such addition can be justified on the basis of *facility-specific utilization*, geographic remoteness or both . . . . [Emphasis added.]

25. Although the emergency regulation containing this provision was not in effect when DePaul and Virginia Beach General submitted their applications seeking operating room capacity in PD 20 (both of which were received by the Department on January 29, 2001), the Board of Health has begun the regulatory process necessary to make this provision permanent.

26. At the June 2001 IFFC held to discuss the two present applications, the executive director of EVHSA asserted that

> any reasonable person would have to conclude that the institutional need provision was added to the SMFP availability standard in January 2000 just to recognize and codify past case decisions of the Commissioner, and the fact that it expired on January 2 of this year is simply irrelevant to the [Virginia Beach General application] . . . .

C. Facts Surrounding the Present Applications

27. Data from the 2000 U.S. census, indicates population increases and decreases in the cities of PD 20, as shown in the table below.

Change in Population of PD 20 Cities

City	1990 Census Population	2000 Census Population	Percentage Change
Chesapeake	151,982	199,184	31.0
Norfolk	261,250	234,403	-10.3
Portsmouth	103,910	100,565	-3.2
Suffolk	52,143	63,677	22.1
Virginia Beach	393,089	425,257	8.2

28. In March 1999, the Virginia Employment Commission (VEC) made projections that overestimated the 2000 population of Virginia Beach and Chesapeake, when compared to actual 2000 populations of these cities, by 2.5 percent and almost four percent, respectively. Growth in these two cities proved to be smaller than had been expected. The VEC projection of the 2000 population of the City of Norfolk underestimated that city's actual population by over four percent, as shown in the following table.

Actual 2000 Population of Three PD 20 Cities Compared to 1999 VEC Estimates

City	Actual 2000 Population	1999 VEC Estimates of 2000 Population
Virginia Beach	425,257	436,000
Chesapeake	199,184	206,997
Norfolk	234,403	224,998

29. On March 20, 2001, the [Norfolk] *Virginian-Pilot* published an article in which it observed that the southern Hampton Roads area is a "once-booming region [that] maintains growth with births, [and] population shifts." Reviewing 2000 census data, the newspaper concluded that

> [m]ore people are moving out of Hampton Roads than moving in, despite the region's 8.5 percent growth in the '90s. . . . For years, Hampton Roads thought of itself as the growth capital of Virginia, and for a while, that was true. In the 1980s, Virginia Beach was one of the boomingest cities in America. Now the movement is mostly inside Hampton Roads, between cities. It's that movement, along with the birth rate, that explains why Chesapeake, Virginia Beach and Suffolk grew, while Norfolk and Portsmouth shrank.

30. PD 20 currently has a total of 151 ORs. The Virginia Department of Health, Division of Certificate of Public Need estimates, through application of the computational methodology contained in 12 VAC 5-270-40 A, that PD 20 will have a surplus of nine ORs in 2004. This would be a surplus of seven percent. (EVHSA estimates that PD 20 will have a surplus of eight ORs in 2004.)

31. Despite the surplus, the ORs in PD 20 exhibits a high level of utilization in recent years, due in part to very high utilization at Chesapeake General Hospital (which opened a four-OR OSH in May 2001) and high utilization at Virginia Beach General. Overall, the utilization of general purpose ORs is higher than that of ORs in OSHs in PD 20. Aside from Chesapeake General Hospital, which opened an OSH on its campus in May 2001, Virginia Beach General had the highest OR utilization rate in 1999, as shown in the following tables.

General Purpose Operating Room Utilization in PD 20, 1996-1999

Hospital	Number of ORs in 1999	Occupancy per OR (As a Percentage of the 1600-Hour-per-Year Standard)			
		1996	1997	1998	1999
Chesapeake General Hospital	10	109.7	131.4	135.8	150.9*
CHKD	8	78.4	66.0	68.6	69.0
Bon Secours DePaul	10	67.4	63.0	58.8	57.9
Maryview Medical Center	9	93.0	128.0	162.5	104.8**
Norfolk Community Hospital	n/a	69.6	79.3	Closed	Closed
Obici Memorial Hospital	8	58.7	65.9	73.7	73.1
Portsmouth General Hospital	n/a	78.7	59.7	110.6	Closed
Sentara Bayside Hospital	7	77.2	91.0	96.0	91.6
Sentara Leigh Hospital	11	74.0	79.7	100.5	105.5
Sentara Norfolk General Hospital	23	104.1	109.1	110.6	112.0
Southampton Memorial Hospital	3	63.1	64.1	53.1	53.1***
Sentara Virginia Beach General	9	115.0	124.5	123.8	132.7
Hospital Total and Average	98	86.9	93.9	103.2	101.0

*Chesapeake General OSH opened in May 2001
**Maryview Medical Center added a ninth OR in 1999
***1999 data at Southampton Memorial Hospital were not available; 1998 data substituted for 1999

Ambulatory Operating Room Utilization in PD 20, 1996-1999

Outpatient Surgical Hospitals (Ambulatory Surgery Centers)	Number of ORs in 1999	Occupancy per OR (As a Percentage of the 1600-Hour-per-Year Standard)			
		1996	1997	1998	1999
Bon Secours Harbour View (opened in 1999)	6	n/a	n/a	n/a	32.2
Lakeview Medical Center	2	52.3	30.2	47.5	28.6
Sentara Leigh Ambulatory Surgery	6	51.1	55.8	58.7	58.7
Sentara Virginia Beach Ambulatory Surgery	4	88.3	96.2	100.8	106.7
Ambulatory Surgery Center Total and Average	18	64.9	65.0	70.9	57.2

General Purpose and Ambulatory Operating Room Utilization in PD 20, 1996-1999

PD 20 Total and Average	Number of ORs in 1999	Occupancy per OR (As a Percentage of the 1600-Hour-per-Year Standard)			
		1996	1997	1998	1999
	116	85.0	91.1	99.8	94.2

32. The application submitted by DePaul, to which CKDH was added as a co-applicant following the initial analysis performed by EVHSA and at the April 2001 public hearing scheduled to consider the two present applications, proposes the establishment of an OSH consisting of four general purpose ORs and two "minor treatment" rooms.

33. DePaul states an intention to close four general purpose ORs at its medical center in Norfolk if the Commissioner were to approve the application for an OSH. DePaul asserts that its application constitutes a "relocation" of ORs, and that the analysis appropriate to the proposal involves primarily the question whether it will "improve the distribution of surgical services within a [PD]," as contemplated by 12 VAC 5-270-40 B, which discloses a discretionary ability to approve a project proposing the relocation of ORs. If approved, this proposal would result in no increase in the number of general purpose ORs in PD 20.

34. At the IFFC held to discuss the two present applications, the executive director of EVHSA asserted that "it is hard to imagine surgical services being better distributed [in PD 20] . . . unless one believes that they out to be located on every street corner like 7-Elevens."

35. The total capital costs of the DePaul project would be $2,957,725. DePaul represents that project would be funded through available accumulated reserves. The proposed OSH would involve 23,453 square feet of leasehold improvements.

36. The application submitted by Virginia Beach General proposes the addition of two ORs to the hospital's current surgical suite of 14 ORs, which in 1999 operated at a 115 percent of the 1,600 hour-per-year standard contained in the SMFP. If approved, this proposal would increase the surplus of ORs in PD 20 to a total of eleven.

37. The total capital costs of the Virginia Beach General project would be $1,540,798. Virginia Beach General represents that its project would be funded through available accumulated reserves.

The proposed project would involve construction of a 2,902-square foot addition at the rear of the hospital.

38. As the following table shows, DePaul Medical Center provided a level of charity care equivalent to 4.5 percent of its gross patient revenues in 1998 and 4.1 percent in of such revenues in 1999 – the highest levels of such care provided by any hospital in PD 20. Virginia Beach General's level of charity care totaled 2.0 percent in both 1998 and 1999. The median charity care level for PD 20 was 1.4 percent in 1998 and 1.2 percent in 1999.

Charity Care at Bon Secours-DePaul Medical Center,
Virginia Beach General Hospital and Children's Hospital of the King's Daughters

	1998			1999		
	Gross Patient Revenue	Total Charity Care	Percent	Gross Patient Revenue	Total Charity Care	Percent
DePaul	$112,120,105	$5,002,224	4.5	$119,717,590	$4,911,115	4.1
Virginia Beach General	$204,224,421	$4,035,426	2.0	$222,850,378	$4,508,361	2.0
CHKD	$134,519,193	$244,033	0.2	148,009,878	$105,698	0.1
		HPR V Median	1.4			1.2

39. CHKD asserts that it maintains a "commendable commitment to charity care as well," which is not apparent, in part, because over half of its patient base receives Medicaid benefits. CHKD notes that "[a]lthough the actual percentages appear low, CHKD's extensive efforts to provide patients with access to federal and state aid programs has driven this decline." CHKD also represents that it maintains its own charity care program with "provides services free of charge to patients whose families earn too much to qualify for Medicaid but are within 200% of the poverty guidelines."

40. The staff and board of EVHSA recommends denial of the application submitted by DePaul and approval of the application submitted by Virginia Beach General.

41. By letters dated May 21, 2001, DCOPN informed the applicants that it recommends approval of the application submitted by DePaul and denial of the application submitted by Virginia Beach General.

42. On May 25, 2001, and pursuant to Sections 32.1-102.6 (D) and (G) of the Virginia Code, Chesapeake General Hospital submitted a written petition to establish good cause to be a party to the IFFC scheduled to discuss the DePaul and Virginia Beach General applications on June 6, 2001; Chesapeake General specifically sought to establish good cause in relation only to the DePaul-CHKD application.

43. The Commissioner and the adjudication officer writing this recommendation reviewed Chesapeake General's petition on June 5, 2001; after that review, the Commissioner found that Chesapeake General had demonstrated good cause, inasmuch as the record indicated the existence of "significant relevant information not previously presented at and not available at the time of the public hearing" conducted by EVHSA and "substantial material mistake[s] of fact or law in the Department staff's report on the application" – the first and third of three criteria by which good cause may be demonstrated. After a preliminary IFFC held on June 6, 2001, to discuss the good cause petition, the adjudication officer confirmed the Commissioner's finding that Chesapeake General had demonstrated good cause to be a party to the IFFC and announced that finding to the parties attending the IFFC.

44. DePaul-CHKD has since maintained that the Commissioner erred in "delegating her authority" to the adjudication officer in determining whether Chesapeake General demonstrated good cause.

45. An informal fact-finding conference (IFFC) was convened on June 6, 2001, in Richmond pursuant to Sections 9-6.14:11 and 32.1-201.6 of the *Code of Virginia* to discuss the DePaul-CHKD and Virginia Beach General applications. All three applicants were represented by counsel at this IFFC.

II. DISCUSSION

A. The Good Cause Petition and Confirmation of the Finding of Good Cause

Section 32.1-102.6 (D) of the Virginia Code specifies that the determination of whether public need exists for a proposed project shall be made in accordance with the provisions of the Administrative Process Act (Currently Section 9-6.14:1 *et seq.* of the Code, to be recodified at Section 2.2-4000 *et seq.* effective October 1, 2001) "except for those parts of the determination process for which timelines and specifications are delineated in . . . [the COPN law]. Further, the parties to the case shall include only the applicant, *any person showing good cause*, any third-party payor . . . [that meets the requirements further specified therein], or the health planning agency if its recommendation was to deny the application. [Emphasis added.]"

Section 32.1-102.6 (G) of the Code also defines "good cause," for purposes of determining which parties may participate in an IFFC to review a COPN application, to mean "that (i) there is significant relevant information not previously presented at and not available at the time of the public hearing, (ii) there have been significant changes in factors or circumstances relating to the application subsequent to the public hearing, or (iii) there is a substantial material mistake of fact or law in the Department staff's report on the application or in the report submitted by the health planning agency."

Chesapeake General's May 25, 2001, petition for good cause standing asserts, among other things, grounds for finding good cause, in relation only to the application filed by DePaul-CHKD, based on the first and third enumerated items of the good cause definition.

Chesapeake General's petition alleges there was significant relevant information not previously presented at and not available at the time of the public hearing, specifically, documentation detailing the financial and institutional relationship between DePaul and CHKD had not been provided.

Chesapeake General's petition also alleges that the staff report reviewing the DePaul-CHKD and Virginia Beach General applications, prepared by DCOPN, contains the following substantial material mistakes of law and fact:

(i) Including "surgical endoscopic-cystoscopic special procedure rooms" in the general inventory of operating rooms in a planning district;

(ii) Inconsistently identifying the number of ORs currently held by the applicants;

(iii) Concluding that implementation of the DePaul-CHKD OSH will generate cost savings to surgical patients in PD 20, despite the adverse effect diminished utilization would have on costs and charges for surgical and other services at DePaul and CHKD, which have under-utilized ORs;

(iv) Failing to address the two apparent intentions behind the DePaul-CHKD application, specifically, to "allow DePaul to continue to serve its historical charity mission while maintaining the necessary growth in revenues which all health care institutions must achieve in today's challenging economic environment," and, as stated by DePaul at the public hearing according to Chesapeake General Hospital, "to serve a younger population implying a different, new patient base than it now serves;"

(v) Rejecting the assertion that the OSH proposed by DePaul-CHKD will capture surgical patients now served by Chesapeake General's OSH, and other OSHs, thereby increasing costs at those facilities;

(vi) Failing to assess the financial impact of the proposed OSH on CHKD and concluding that CHKD would redirect 1,633 surgical procedures to a facility "in which its ownership interest was unclear as late as the public hearing and is yet to be clarified," according to Chesapeake General;

(vii) Incorrectly identifying the date on which an emergency regulation expired, specifically involving the January 2, 2001, expiration of an amendment to 12 VAC 5-270-40, which set forth the standing policy of gauging a hospital's institutional need, when warranted to otherwise carry out the intent of the COPN law (and discussed in detail below); Chesapeake General contends that this error implied that the 1999 approvals of Chesapeake General's OSH was based, in substantial part, on the existence of this regulatory provision when in fact those approvals occurred before the emergency regulation became effective on January 3, 2000;

(viii) Incorrectly observing that the proposed OSH will improve Virginia Beach residents' access to "specialized pediatric surgical services," when the DePaul-CHKD amended application indicates that "routine" [pediatric] surgeries such as ear tubes, tonsillectomies and hernia repairs" would be provided that the proposed OSH;

(ix) Incorrectly projecting, and thereby exaggerating, population growth in the cities of Chesapeake and Virginia Beach, where DePaul-CHKD proposes to locate the proposed OSH, noting the Commissioner's previous observation that there is no "one-to-one," or directly proportionate, relationship between population growth and utilization of surgical services; and

(x) Omitting any detailed discussion of the adverse effect of the DePaul-CHKD proposal on Chesapeake General's OSH, which opened in the area on May 1, 2001, noting that in her June 22, 2000, denial of DePaul's application for an OSH and of an OSH proposed by the Sentara Healthcare system, the Commissioner found that "in view of the recent authorization of . . . [the Chesapeake General OSH], there is no evidence of need for additional surgical facilities . . . in Virginia Beach . . . ."

On June 5, 2001, the Commissioner personally reviewed Chesapeake General's petition with the adjudication officer and found reason to believe that good cause had been established. She also, on that day, directed the adjudication officer writing this recommendation to announce at the following day's IFFC her finding of good cause, provided he would, at that time, have been presented with no additional evidence or argument that weighed heavily against such a finding.

On June 6, 2001, the date of the previously-scheduled IFFC to review the DePaul-CHKD and Virginia Beach General applications, *i.e.*, the "IFFC-in-chief," the adjudication officer conducted a preliminary "good cause IFFC" to hear Chesapeake General, by counsel, on its petition and to allow DePaul-CHKD to respond. Following these presentations, the adjudication officer announced and confirmed the Commissioner's finding that Chesapeake General had demonstrated good cause.

DePaul-CHKD immediately challenged the finding, arguing that the Commissioner had improperly delegated her authority to the adjudication officer to make a determination regarding good cause. Such a contention reflects a fundamental misunderstanding of the facts and the law.

Regardless of any inconsistencies in the record describing or referring to the finding of good cause in this case and its subsequent announcement, the Commissioner's action was proper and essentially involved no delegation of authority to the adjudication officer to make a primary judgment. After directly reviewing Chesapeake General's petition, she found that good cause had been demonstrated. Her subsequent directive to the adjudication officer was simple, prudent and appropriate: If, after hearing evidence and argument on the petition, nothing substantially weighs against her finding of good cause, the adjudication officer was authorized to announce the finding on June 6; if any evidence or argument weighed heavily against the appropriateness of announcing the Commissioner's finding of good cause, the adjudication officer was to refrain from announcing the finding, pending further review by the Commissioner and discussion between the Commissioner and the adjudication officer.

This arrangement involved no delegation of the authority to find good cause, as DePaul-CHKD erroneously alleges. The Commissioner had found good cause after a direct review of the pertinent documents. Indeed, any delegation involved was a narrow, appropriate and economical one, involving only the announcement of the finding of good cause in the event no substantial evidence surfaced to weigh against such a finding, to be made to all interested persons as soon as was prudent in order to benefit them with timely notice of the finding.

In the alternative, DePaul-CHKD has asserted that a determination whether good cause exists should be delayed until after the record in this matter closed, which occurred on July 6, 2001. A finding of good cause is made on a relatively narrow basis of fact – one that is not dependent on development of the entire record relating to an application. In this case, the issues surrounding the good cause matter involve an analysis primarily of the DCOPN staff report, a document unchanged since its issuance May 21, 2001, and Chesapeake General's May 25 petition. Delay, or rather, suspension, of a finding appropriately made and announced to all interested parties, after DePaul-CHKD, the complaining applicant, had a meaningful opportunity to respond to the petition, would constitute the granting of unfair and special consideration to DePaul-CHKD.

As the facts and discussion relating to the DePaul-CHKD application, located throughout this recommendation, demonstrates, sufficient grounds exist to support the Commissioner's June 5, 2001, finding that Chesapeake General has demonstrated good cause, based on the existence of significant relevant information not previously presented at and not available at the time of the public hearing, and on the existence of numerous substantial material mistakes of fact or law in the DCOPN report. Specifically, these grounds include the failure of DePaul and CHKD to bring to light at the time of the public hearing, in a manner typical to similar arrangements in past COPN applications, details regarding the partnership arrangement between them – significant relevant information, and the failure of DCOPN to prevent many of the shortcomings in its staff report identified by Chesapeake General and set forth numerically above.

B. Review of the Applications in Relation to the Law

Section 32.1-102.3 B of the Code of Virginia requires that, in determining whether a public need for a proposed project has been demonstrated, the State Health Commissioner shall review an application for a certificate of public need in relation to the twenty considerations enumerated in that section. The following is a discussion of the application of the Authority for adding MRI services at Stony Point in relation to these considerations.

1. The recommendation and the reasons therefor of the appropriate regional health planning agency.

On May 8, 2001, the board of directors of the Eastern Virginia Health Systems Agency (EVHSA) recommended approval of the Virginia Beach General project and denial of the DePaul-CHKD project. The motion recommending approval of the first project and denial of the second was carried by a vote of eight in favor, one opposed, with two abstentions.

EVHSA recommends approval of the Virginia Beach General project to add two general purpose operating rooms because:

(i) The proposed project is "fully consistent with the entire relevant component of" the SMFP;

(ii) The proposed project would not have a negative impact on the utilization, costs, or charges of any other provider of surgical services in PD 20;

(iii) The proposed project would meet the clear institutional need of the applicant to expand its OR capacity; and

(iv) There do not appear to be any less costly or more effective alternatives to the proposed project;

EVHSA recommends denial of the DePaul-CHKD project to establish a four-OR outpatient surgical hospital (OSH) because:

(i) The proposed project is not consistent with the availability standards of the relevant component of the SMFP;

(ii) The proposed project would have a substantial negative impact on the utilization, costs, and charges of other existing providers of surgical services in PD 20 and the Virginia Beach area;

(iii) There are no geographic accessibility or distribution problems in PD 20 or the Virginia Beach area that need to be addressed by the proposed project;

(iv) The proposed project would increase the costs per case, and perhaps, the charges per case as well at the applicants existing hospital facilities; and

(v) The most effective and least costly alternative to the proposed project is not to allow it to be developed.

2. The relationship of the project to the applicable health plans of the regional health planning agency, the Virginia Health Planning Board and the Board of Health.

The applicable health plan is the portion of the State Medical Facilities Plan (SMFP) found at 12 VAC 5-270-10 *et seq*. (Text appearing under this consideration in italics has been selected from the SMFP and precedes discussion of the proposed project in relation to the selected text.)

12 VAC 5-270-20. Acceptability. Self-referral. Surgical services providers should comply with all applicable federal and state statutes governing the ability of physicians to refer patients to facilities in which they have an ownership interest.

No physicians appear to have an ownership interest in either the DePaul-CHKD project or the Virginia Beach General project. This provision, therefore, does not apply to either project.

12 VAC 5-270-30. Accessibility; travel time; financial. Surgical services should be available within a maximum driving time, under normal conditions, of 45 minutes for 90 percent of the population.

Ten hospitals with surgical capacity and five OSHs serve the population of PD 20. These surgical facilities are geographically dispersed throughout PD 20, which enjoys a well developed system of roads and highways, such that surgical services are available to all of the residents of PD 20 within 45 minutes' driving time, assuming favorable driving conditions.

The assertion by DePaul-CHKD that relocation of four ORs from DePaul Medical Center in Norfolk to the proposed OSH in Virginia Beach would "improve distribution" of surgical resources by correcting a "gross maldistribution" appears unconvincing in relation to the uncontested prevalence of compliance with this standard. Straightforward analysis indicates acceptable access to surgical services in PD 20 – a fact undisputed by the parties to these applications.

Surgical services should be accessible to all patients in need of services without regard to their ability to pay or the payment source.

As discussed in detail in the findings of fact, above, both DePaul and Virginia Beach General annually provide charity care well in excess of the median level of charity care provided by other hospitals in HPR V.

DePaul provided a level of charity care equivalent to 4.5 percent of its gross patient revenues in 1998 and 4.1 percent in of such revenues in 1999 – the highest level of such care in PD 20. DePaul represents that its level of charity care approximated 7.3 percent in 2000. Virginia Beach General's level of charity care totaled 2.0 percent in both 1998 and 1999. The median charity care level for PD 20 was 1.4 percent in 1998 and 1.2 percent in 1999.

DePaul and CHKD represent that they "will continue to treat each patient without regard to the patient's ability to pay." As discussed in the findings of fact, above, CHKD appears to assist actively in providing care to lower income patients, despite the ostensibly low level of charity care indicated by a conventional juxtaposition of the value of the hospital's outright charity care to its gross patient revenue. The failure, however, of the computational methodology used by the Department and Virginia Health Information to capture and accurately portray the charity care of CHKD, along with various other facilities in Virginia, is surprising.

12 VAC 5-270-40. Availability; need. A. Need. The combined number of inpatient and ambulatory surgical operating rooms needed in a planning district will be determined . . . [according to the computational methodology set forth in this provision, which includes factors such as (i) recent operating room utilization, (ii) recent and projected population, and (iii) the average length of operating room visits].

No additional operating rooms should be authorized for a planning district if the number of existing or authorized operating rooms in the planning district is greater than the need for operating rooms identified using . . . [this] methodology. New operating rooms may be authorized for a planning district up to the net need identified by subtracting the number of existing or authorized operating rooms in the planning district from the future operating rooms needed in the planning district, as identified using the [methodology set forth in this subsection].

Like many provisions of the SMFP, this one seeks to ensure that ORs in a PD are optimally utilized and that facilities do not undertake capital investments which would not be used efficiently.

Currently, a total of 151 ORs serve PD 20. Use of the methodology set forth in this provision indicates that PD 20 will need a total of 142 ORs in 2004, and that, therefore, PD 20 has a current surplus of nine ORs.

Several recent approvals of applications for COPNs, including those noted above, recognize, despite the existence of a surplus within a particular PD, that at times an individual facility's institutional need may justify expansion of OR capacity. These decisions reflect the reality that excess capacity in a PD does not adequately compensate for need experienced at a particularly well-utilized facility.

Regardless of whether close consideration of these past decisions constitutes *stare decisis*, which DePaul-CHKD argues in a post-IFFC submittal is inappropriate within the context of

administrative decision-making, the case that applicant cites – *Courtesy Motors, Inc. v. Ford Motor Co.*, 9 Va. App. 102, 106, 384 S.E.2d 118, 120 (1989) – clearly states that although "[a]n agency may refuse to follow its own precedent, . . . it must not act arbitrarily in doing so."

The measured consideration, and reliance where appropriate, of an administrative agency on its own previous decisions constitutes a reasonable effort to impart predictability and stability to an area of regulated activity. Properly considered and applied, such reliance provides a springboard for the application of settled principles to similar, newly-encountered situations; it need not, should not, and does not in the present matter, operate to allow previous decisions to dictate the outcome. However, failure to consider such previous decisions would likely constitute arbitrary and capricious behavior.

In the adjudication officer's April 1999 recommendation regarding the three competing applications of DePaul, Chesapeake General Hospital and the Sentara Health System seeking authority to establish an OSH in PD 20, he notes a surplus of ORs in PD 20 of 31 – far greater then than the current computation indicates – and notes further that

> only one [applicant], [Chesapeake General], can make a good case for constructing new operating rooms in PD 20, on a *small-area basis*. It is currently being utilized above the [1,600 hour-per-year] standard for operating room use. [Emphasis added.]

The brevity with which the adjudication officer refers to the institutional need he had identified at CGH in 1999 speaks forcefully of the existence of a policy of looking at "institutional need," when warranted by the facts, as a planning device in allocating health care resources, despite the status of efforts to adopt permanently this policy following lapse of the 2000 emergency regulation, discussed in the findings of fact, above. DePaul-CHKD attempts to attach undue significance to this lapse in an effort to discount the policy of considering an institution's need, which was determinative in approving applications submitted and reviewed before the emergency regulation became effective, including Chesapeake General's 1997 application for two ORs and its 1999 application for two additional ORs.

Similarly, in the present matter, Virginia Beach General appears to have a strong institutional need for additional operating capacity. At the IFFC held to discuss the present applications, the executive director of EVHSA asserted that "the Commissioner's decisions have recognized that high volume providers should not be punished for having high utilization but instead should be allowed to expand capacity." Virginia Beach General's nine general purpose ORs reported 19,108 surgical hours in 1999, which equates to the use of almost 12 general purpose ORs based on the 1,600-hours-per-year standard and to a utilization rate of over 132 percent. EVHSA's report observes that Virginia Beach General "is clearly being conservative in asking for only two more ORs when it could conceivably justify at least three more general purpose ORs."

Virginia Beach General represents that its prevailing high utilization translates into challenging conditions, in which surgical services are

> not provided in a manner optimal for patients, physicians, or staff. Waiting times re often two weeks for routine surgeries, and up to six weeks for elective surgeries. The OR[s] operate[] from 6:00 a.m. and often [have] surgeries that do not start until late in the evening, or sometimes after midnight. It is an all-too-common occurrence for

surgeries to go on well into the early morning hours, simply because those surgeries were not able to begin until late in the evening due to lack of OR space. Such a schedule is difficult on physicians, but more importantly is not optimal for patients, who often have been waiting a long time to access the OR and whose family support services are more difficult to access late in the evening.

An orthopedic surgeon who serves as chair of the Virginia Beach General Department of Surgery states that "[o]ftentimes elective surgeries are scheduled two months or more in advance. . . . [Virginia Beach General] and the physicians that work there enjoy very good reputations in the community and in the outlying areas. They continue to attract patients from Virginia Beach and from outlying areas and our surgical caseload has continued to increase."

Aside from Chesapeake General Hospital, which opened an OSH on its campus in May 2001, Virginia Beach General had the highest OR utilization rate of any hospital or OSH in 1999, as shown in the following table.

General Purpose Operating Room Utilization in PD 20, 1996-1999

Hospital	Number of ORs in 1999	Occupancy per OR (As a Percentage of the 1600-Hour-per-Year Standard)			
		1996	1997	1998	1999
Chesapeake General Hospital	10	109.7	131.4	135.8	150.9*
CHKD	8	78.4	66.0	68.6	69.0
Bon Secours DePaul	10	67.4	63.0	58.8	57.9
Maryview Medical Center	9	93.0	128.0	162.5	104.8**
Norfolk Community Hospital	n/a	69.6	79.3	Closed	Closed
Obici Memorial Hospital	8	58.7	65.9	73.7	73.1
Portsmouth General Hospital	n/a	78.7	59.7	110.6	Closed
Sentara Bayside Hospital	7	77.2	91.0	96.0	91.6
Sentara Leigh Hospital	11	74.0	79.7	100.5	105.5
Sentara Norfolk General Hospital	23	104.1	109.1	110.6	112.0
Southampton Memorial Hospital	3	63.1	64.1	53.1	53.1***
Sentara Virginia Beach General	9	115.0	124.5	123.8	132.7
Hospital Total and Average	98	86.9	93.9	103.2	101.0

*Chesapeake General OSH opened in May 2001
**Maryview Medical Center added a ninth OR in 1999
***1999 data at Southampton Memorial Hospital were not available; 1998 data substituted for 1999

Inasmuch as DePaul-CHKD proposes a project that, in its totality, seeks to relocate four underutilized ORs and construct two minor treatment rooms, its approval would not involve an addition to the inventory of general purpose ORs in PD 20.

B. Relocation. Projects involving the relocation of existing operating rooms within a planning district may be authorized when it can be reasonably documented that such relocation will: (i) improve the distribution of surgical services within a planning district; or (ii) result in the provision of the same surgical services at a lower cost to surgical patients in the planning district; or (iii) optimize the number of operations in the planning district which are performed on an ambulatory basis.

This provision contains the discretionary modal verb "may," as opposed to "shall," and thereby, *allows* the Commissioner, but does not require her, to approve relocations, in her discretion, where

such projects are warranted under one or more of the three alternatives listed and are otherwise justifiable under the general analysis afforded applications for COPNs under the COPN law and applicable provisions of the SMFP. Notably, the law includes the fourth statutory consideration, set forth below, designed to gauge, in a general way, the population's need for a proposed project, and the ninth and sixteenth considerations, designed to force analysis of the systemic effects of a proposal and the costs and benefits it promises. The relocation provision does not nullify the requirement of an investigation of need simply because a proposed relocation of ORs would serve the interest of availability or increase the convenience of physicians and patients.

DePaul-CHKD argues that this provision effectively removes proposed projects to relocate ORs from operation of the methodology by which need is calculated, set forth in 12 VAC 5-270-40 A. At the IFFC, DePaul and CHKD argued that "[w]e are not here to solve so much an access problem as we are to improve the distribution . . . . [The] relocation standard doesn't turn on whether the planning district has a surplus or not or whether access is reasonable or not . . . . The issue is improvement of distribution . . . ." DePaul and CHKD maintain that their proposal is necessary to address a "maldistribution" of ORs in PD 20.

The relocation standard has been codified in a section of the SMFP affirmatively relating to "availability" and "need." While the concept of availability may be distinguishable from that of "access" (which deals, for example, with a patient's ability to drive to and gain the benefit of a certain medical resource or service), availability is closely related to the determination of a population's need for a certain resource, often quantified through use of a specific methodology, along with the issues whether the quantity of facilities offering that resource is sufficient and whether the resources are determined to be readily at hand when needed.

The methodology by which DePaul-CHKD seeks to prove the existence of maldistribution and to assert its solution appears purposely designed to "reasonably document[]" an improvement in distribution, however, it is an untested creation at odds with a standard interpretation of the law, in this case, the regulatory provisions contained in the SMFP, inasmuch as a specific methodology for calculating planning district-wide need for ORs has been adopted in regulation, while no similar methodology has been set forth for gauging the appropriateness of a proposed relocation of ORs.

Specifically, DePaul-CHKD asserts that the appropriate methodology for analyzing its proposal for an OSH involves application of the methodology for determining surgical need in a planning district (as set forth in the SMFP and discussed above) in a local manner, *i.e.*, in the present case, along jurisdictional lines, or city by city. DePaul-CHKD argues that use of this hybrid approach demonstrates a maldistribution that must be corrected.

Under the analysis offered by DePaul-CHKD, distribution of ORs in PD 20 contrasts discernibly with population. The City of Virginia Beach maintains 20 general purpose ORs while the City of Norfolk maintains 58. Yet Virginia Beach, relying on 1999 estimates of 2000 population made by the Virginia Employment Commission (VEC), has an estimated 2004 population of 461,601 and Norfolk has a 2004 population of 221,000. By operation of the SMFP methodology to these localities, DePaul-CHKD concludes that Norfolk has a surplus of 35 ORs and Virginia Beach has a need for 27 ORs.

The methodology created by DePaul-CHKD may be helpful in plumbing the appropriateness of a planned relocation, where it is taken for illustrative purposes, with the full weight of other evidence relating to public need and in full appreciation of the COPN law and other provisions in the SMFP that require broader and systemic considerations. But such an analysis cannot, by itself, be determinative of whether an application should be authorized, as a surfeit of other provisions in the COPN law and the SMFP exist to guide the Commissioner, especially when that application appears likely to capture patients from existing providers in a targeted area.

Indeed, the Commissioner has historically determined the need for ORs on a planning district-wide basis, and in certain circumstances, on an institutional need basis, as demonstrated by the April 1997 approval, and October 1999 approval of an expansion, of the OSH recently opened by Chesapeake General in Virginia Beach. Perhaps the clearest means of gauging the distribution of ORs within a planning district that has a surplus, a task taken within the context of determining availability, after all, is by reference to driving times, for which the SMFP provides a specific criterion at 12 VAC 5-270-230, discussed above. Clearly, residents have ready access to surgical services, as they are available to all of the residents of PD 20 within 45 minutes' driving time. In a post-IFFC submission, EVHSA observes that

> the implied notion that Norfolk and its health care facilities are far removed from Virginia Beach is simply wrong geographically. . . . [I]n a densely populated, compact urban area like the four-city Norfolk, Virginia Beach, Chesapeake, Portsmouth area, it is simply irrelevant that the distribution of ORs does not follow the distribution of population . . . . *DePaul readily admits that it simply wants to expand the number of Virginia Beach patients it serves and [to] make more money*. That's hardly proof that there is a distribution problem in PD 20. [Emphasis added.]

Straightforward analysis indicates acceptable access to surgical services in PD 20 – a fact undisputed by the parties to these applications. Observation also indicates the absence of any critical, overall problem with access to or availability of surgical services in PD 20, such as might derive from the purported "maldistribution" DePaul-CHKD seeks to establish.

C. Ambulatory surgical facilities. Preference will be given to the development of needed operating rooms in dedicated ambulatory surgical facilities developed within general hospitals or as freestanding centers owned and operated by general hospitals.

DePaul-CHKD asserts that their proposed project should receive a preference under this provision, insofar as the proposal would constitute a "freestanding ambulatory surgery center . . . owned by [DePaul and CHKD]."

Application of this provision, and creation of a resulting preference, is fundamentally predicated on the identification of a need for the proposed services. No credible need for the proposed OSH has been demonstrated, therefore the preference does not apply to the DePaul-CHKD proposal.

12 VAC 5-270-50. Cost; charges. Preference among competing applications to provide surgical services identified as needed in a planning district will be given to applicants who can reasonably document that the costs of providing services and the charges for these services will be less than the

average costs and charges for comparable services provided in the planning district or health planning region in which the project is to be located, consistent with the other standards of this plan component.

Like the provision discussed directly above, application of this provision, and creation of a resulting preference, is fundamentally predicated on the identification of a need for the proposed services.

Since both the DePaul-CHKD and the Virginia Beach General applications would be funded through accumulated reserves, financing charges and interest on debt would not be incurred by either as a result of implementing the proposed projects.

DePaul and CHKD represent that the proposed OSH has been purposely designed to reduce costs and charges relating to outpatient surgical services. DePaul would relocate much of the surgical equipment currently located at DePaul Medical Center to the proposed OSH. DePaul and CHKD also maintain that establishment of the OSH will "achieve additional efficiencies and savings through shared services . . . with other Bon Secours facilities and CHKD," and that these savings will translate into "lower charges to patients," compared with other area hospitals. DePaul predicts that DePaul Medical Center will realize savings of $2,413,896 and CHKD predicts that it will realize savings of $1,419,185 if the OSH proposal were approved.

As discussed above, however, any savings accruing from the DePaul-CHKD proposal would likely be limited because a substantial portion of outpatient surgeries performed at DePaul and CHKD would be shifted to the proposed OSH, the number of outpatient surgeries at these existing hospitals would fall, the average cost per procedure there would increase. DePaul and CHKD represent that a team of pediatric surgeons and support staff from CHKD would go to the proposed OSH one day a week and possible two days a week.

Based on CHKD's representation that approximately 1,600 pediatric surgery cases would be transferred from CHKD to the proposed OSH, EVHSA estimates that the outpatient volume at CHKD would fall about 29 percent. EVHSA also estimates that all of DePaul's outpatient surgery patients living in Virginia Beach and Chesapeake – totaling at least 1,874 annually – would be served at the proposed OSH, resulting in a 24 percent drop in outpatient surgeries at DePaul Medical Center. EVHSA concludes that reductions in patient volume of this magnitude are bound to result in increased costs, and possibly charges, at the existing hospitals, as fixed costs would be spread over a smaller number of patients. EVHSA's analysis, however, may not take adequate account of the cost savings that may accrue from reduction of surgical staff at DePaul Medical Center and the related possibility that DePaul may identify and implement more productive use of the space presently dedicated to underutilized surgical capacity.

EVHSA observes that the cost per surgical case involved in the present application submitted by DePaul-CHKD reflects a 29 percent increase over costs associated with DePaul's 1997, 1999, and 2000 applications to establish an OSH in Virginia Beach. Former costs ranged from $733 to $899 per case, while the present application estimates costs to be $1,165 per case.

Recent data indicate that Virginia Beach General placed in the top quartile of all hospitals in HPR V for cost per adjusted admission.

The total capital cost of the Virginia Beach General project to add two ORs is $1,540,798, which amounts to $770,399 per general purpose OR. The total capital cost of the DePaul-CHKD project to establish a four-OR OSH is $2,957,725, which amounts to just $739,431 per general purpose OR; however, EVHSA notes that this comparatively low cost is misleading because DePaul-CHKD would lease space in the OSH, rather than purchase it. For the first five years of operation, EVHSA estimates that the total costs of the DePaul-CHK project would be substantially more than the capital cost of its first application, submitted in 1997, to establish an OSH in Virginia Beach.

12 VAC5-270-60. Quality; accreditation/licensure. A. Surgical services providers should meet all applicable accreditation standards of the Joint Commission on the Accreditation of Healthcare Organizations or the Association for Accreditation of Ambulatory Health Centers and licensure standards of the Department of Health.

Virginia Beach General, DePaul and CHKD are all licensed by the Commonwealth of Virginia and accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)

B. Existing and proposed providers of surgical services should document the availability of physicians who are board-certified or board-eligible in appropriate surgical specialties.

Both applications contain a roster of medical staff to be associated with and available for the proposed projects. These rosters indicate the availability of board-certified and board-eligible physicians with appropriate credentials in surgical specialties.

3. The relationship of the project to the long-range development plan, if any, of the person applying for a certificate.

None of the applicants have discussed their respective proposed project relative to a long-range plan.

DePaul and CHKD represent that development of their proposed OSH would enable them to respond to "the current and developing health care needs of their service area population."

Virginia Beach General admits that it does not have "a specific long-range development plan, [but that the] project is consistent with the hospital's overall mission of providing optimal access to high-quality, cost-efficient surgical services."

4. The need that the population served or to be served by the project has for the project, including, but not limited to, the needs of rural populations in areas having distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care.

As discussed above, DePaul and CHKD argue that relocation of its ORs through construction of the proposed OSH is necessary to address a maldistribution of ORs in the area. DePaul-CHKD estimates that Virginia Beach will need 27 to 31 additional ORs by 2004 and Norfolk is overserved by

35 to 44 ORs. DePaul and CHKD assert that "[s]uch maldistribution leaves substantial room for improvement in the aggregate distribution of surgical services within PD 20." DePaul-CHKD has, however, failed to prove convincingly the existence of significant maldistribution, which it seeks to demonstrate through the methodology analyzed in the discussion relating to the relocation provision contained in 12 VAC 5-270-40 B, above.

The considerable expense of relocation should not be borne by a health care system in an attempt solely to take advantage of "room for improvement" in the distribution of a resource that is sufficiently distributed, as seen through the lens of the COPN law and the SMFP and through actual circumstance, which involves a heavily urbanized, compact planning district featuring a surplus of ORs and a well-developed system of roads in which all residents can readily gain access to surgical services.

As pointed out above, the relocation provision relating to ORs is set forth in clearly discretionary terms, *i.e.*, the Commissioner *may* authorize a relocation in order to, among other things, improve the distribution of surgical services within a planning district, when other applicable provisions of law and regulation weigh in favor of such a project. Promoting the convenience to health care providers and patients without due consideration of expense, the effect on other facilities, and the myriad principles of sound health planning is not the goal of the COPN law or the SMFP.

No aggregate public need exists for additional ORs in PD 20; approval of the DePaul-CHKD application appears unwarranted, especially in light of its potential to affect adversely existing providers of surgical services in Virginia Beach. The fourth enumerated provision of the COPN law, however, requires close consideration of the "need that the population served or to be served by the project has for the project." This consideration can entail, among other things, a look at the need of the population, or patient base, served by a facility with an institutional need for a proposed project.

Virginia Beach General, which has a surgical suite of nine ORs that has operated at over 115 percent of the 1600-hours-per-year standard since 1996, and currently operates at over 132 percent, clearly has an institutional need for two additional ORs – a need that may extend to that hospital's apparently loyal patient base, *i.e.*, the population, or a portion thereof, to be served.

5. The extent to which the project will be accessible to all residents of the area proposed to be served.

Virginia Beach General states that its "surgical services are accessible for area residents," and that it "provides services to all patients without regard to ability to pay." Virginia Beach General provides a level of charity care equivalent to two percent of gross patient revenue – a rate that is above the HPR V median of 1.2 percent.

DePaul-CHKD states that "[c]onsistent with the policies of Bon Secours [Hampton Roads Health System] and [CHKD], the proposed . . . [OSH] will serve all patients without regard to their ability to pay or source of payment." DePaul Medical Center has a history of leading PD 20 in the provision of charity care. In 1999 DePaul provided a level of 4.1 percent of gross patient revenue, a rate that was significantly higher than the HPR V median of 1.2 percent. In a post-IFFC filing, DePaul asserts that it provided a level of charity care equaling 7.3 of patient revenue in its fiscal year of 2000.

Although CHKD reported contributing a level of only 0.1 percent of gross patient revenue to charity care in 1999, the hospital's efforts to ensure health care to all may not be adequately represented, as stated in the findings and discussed in relation to 12 VAC 5-270-30, above.

The southside area of Hampton Roads, or PD 20, has a well developed system of interstate and state highways and secondary roads that readily provides residents access to existing health care facilities. Geographic access to surgical services in PD 20 is unimpeded when gauged in light of 12 VAC 5-270-30, above – a fact undisputed by the parties to these applications.

6. The area, population, topography, highway facilities and availability of the services to be provided by the project in the particular part of the health service area in which the project is proposed, in particular, the distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care.

Data from the 2000 U.S. census, indicates population increases and decreases in the cities of PD 20, as shown in the table below.

Change in Population of PD 20 Cities

City	1990 Census Population	2000 Census Population	Percentage Change
Chesapeake	151,982	199,184	31.0
Norfolk	261,250	234,403	-10.3
Portsmouth	103,910	100,565	-3.2
Suffolk	52,143	63,677	22.1
Virginia Beach	393,089	425,257	8.2

In March 1999, the Virginia Employment Commission (VEC) made projections of the 2000 populations of various cities and counties in Virginia. DePaul-CHKD relied on these projections in constructing its argument supporting its project to relocate ORs in PD 20, as evinced by one of its exhibits. In its 1999 projections, VEC overestimated the 2000 population of Virginia Beach and Chesapeake, when compared to actual 2000 populations of these cities, by 2.5 percent and almost four percent, respectively. Growth in these two cities proved to be smaller than had been expected. The VEC projection of the 2000 population of the City of Norfolk underestimated that city's actual population by over four percent, as shown in the table below.

Actual 2000 Population of Three PD 20 Cities Compared to 1999 VEC Estimates

City	Actual 2000 Population	1999 VEC Estimates of 2000 Population
Virginia Beach	425,257	436,000
Chesapeake	199,184	206,997
Norfolk	234,403	224,998

On March 20, 2001, the Norfolk *Virginian-Pilot* published an article in which it observed that the southern Hampton Roads area is a "once-booming region [that] maintains growth with births, [and] population shifts." Reviewing 2000 census data, the newspaper concluded that

> [m]ore people are moving out of Hampton Roads than moving in, despite the region's 8.5 percent growth in the '90s. . . . For years, Hampton Roads thought of itself as the growth capital of Virginia, and for a while, that was true. In the 1980s, Virginia Beach was one of the boomingest cities in America. Now the movement is mostly inside Hampton Roads, between cities. It's that movement, along with the birth rate, that explains why Chesapeake, Virginia Beach and Suffolk grew, while Norfolk and Portsmouth shrank.

Overall, population growth in PD 20 has slowed. A migratory pattern from Norfolk to Virginia Beach is discernable. While relocation of ORs from Norfolk to the east, as proposed by DePaul and CHKD, might realize some improvement in distribution, no maldistribution exists. A costly project, such as that proposed by DePaul and CHKD, is not warranted by the observed trends in population change, or the geography, topography and highway system of the area. There is no identified public need for this project, despite the institutional need of Virginia Beach General for additional capacity in its existing surgical suite, especially in light of the well developed transportation system of PD 20, and the potential of the DePaul-CHKD project for adversely affecting existing facilities by capturing the patients of other facilities, including the recently-opened OSH on the campus of Chesapeake General Hospital.

7. Less costly or more effective alternate methods of reasonably meeting identified health service needs.

Despite the surplus of nine ORs in PD 20, Virginia Beach General has a clear institutional need for at least two additional ORs. Virginia Beach General's proposal offers the least costly and most effective method of meeting patients' identified need for increased surgical capacity. At a capital cost of $1.5 million, the hospital will append two general purpose ORs to its existing surgical suite, alleviating congestion within the surgical suite, improving access to hospital-based surgical services, and increasing patient and physician satisfaction. The only alternative to approving this application is, obviously, maintaining existing conditions at Virginia Beach General, which would involve the ORs there continuing to operate significantly over capacity, resulting in the challenges posed by extended hours of operation and delay of procedures, discussed in relation to 12 VAC 5-270-40 A, above. No less costly and more effective alternative appears capable of meeting this institutional need for additional surgical resources.

Since PD 20 has no significant barriers to the accessibility and availability of surgical services, no need for the marginal benefits of relocating DePaul's ORs exists. The less costly and more effective alternative to approving this application is its denial.

8. The immediate and long-term financial feasibility of the project.

All three applicants appear to have sufficient financial reserves necessary to fund and implement successfully their respective projects; the projects are feasible in an immediate and a long-term context.

Whatever savings that might accrue from the DePaul-CHKD proposal, however, would likely be limited because a substantial portion of outpatient surgeries performed at DePaul and CHKD would be shifted to the proposed OSH, the number of outpatient surgeries at these existing hospitals would

fall, and the average cost per procedure there would increase. While this analysis may not take adequate account of the cost savings that may accrue from reduction of surgical staff at DePaul and the related possibility that DePaul may identify and implement more productive use of the space presently dedicated to underutilized surgical capacity, the costs that would be imposed on the health system of PD 20 by establishment of the proposed OSH appear considerable.

DePaul and CHKD represent that a team of pediatric surgeons and support staff from CHKD would go to the proposed OSH one day a week and possible two days a week.

As detailed above in relation to 12 VAC 5-270-50, EVHSA estimates that the outpatient surgical volume at CHKD would fall about 29 percent, and that the same volume would fall 24 percent at DePaul Medical Center if the OSH comes to fruition and achieves its utilization projections. Reductions in patient volume of this magnitude may result in increased costs, and possibly charges, at the existing hospitals, as fixed costs would be spread over a smaller number of patients. Since these effects would inure to the Bon Secours system and to CHKD, the long-term feasibility of this project is questionable. Since the financial and institutional arrangements between Bon Secour-DePaul and CHKD have not been clearly disclosed, the very ability to conduct a reliable analysis of long-term feasibility is impaired.

9. The relationship of the project to the existing health care system of the area in which the project is proposed; however, for projects proposed in rural areas, the relationship of the project to the existing health care services in the specific rural locality shall be considered.

Currently, twelve hospitals provide inpatient and outpatient surgery services in PD 20, and four OSHs also serve the area. Surgical capacity in the area is adequate, and in fact, a surplus of nine ORs prevails.

EVHSA believes the OSH proposed by DePaul-CHKD cannot achieve its utilization projections without drawing patients from existing area hospitals, notably, Chesapeake General and the Sentara hospitals serving Virginia Beach. Establishment of the OSH would decrease utilization at these hospitals and increase attendant costs, and potentially, charges, thereby having a detrimental effect on the health system of PD 20.

Further, EVHSA discounts DePaul-CHKD's contention that approval of the proposed OSH is desirable because it would allow DePaul Medical Center a greater means to defray the cost of the considerable charity care it provides and that the hospital needs the OSH because Norfolk is losing population the hospital is being financially harmed. EVHSA notes that outpatient surgical volume at DePaul Medical Center increased by 19.8 percent from 1995 to 1999, despite a decrease in the population of Norfolk, and that DePaul Medical Center made $3.58 million from operations on net patient revenue of $75.88 million in 1999, outperforming two other hospitals in the area – Sentara Bayside Hospital and Sentara Hampton General Hospital.

Virginia Beach General provides general health care services at a relatively low cost, is a Level Two trauma center serving the area, offers open heart surgery, and has a surgery suite that has been operating beyond capacity for several years. (The hospital's trauma designation and its open heart surgery program requires that two of its nine ORs regularly be reserved for trauma and heart surgery.)

Two additional ORs at Virginia Beach General would benefit that hospital directly and benefit the existing health care system indirectly. The Virginia Beach General project appears not to pose an adverse effect on other facilities, as the proposed increase in capacity there would serve an institutional need, *i.e.*, a need relating to that facility's effort to serve its current and anticipated patients currently met with some challenge.

10. The availability of resources for the project.

The applicants intend to fund their respective project out of accumulated reserves. They have adequate staffing resources to implement the projects. The OSH proposed by DePaul and CHKD would require 24 full-time equivalent employees, which would be transferred from affiliated facilities. The project proposed by Virginia Beach General may necessitate a marginal increase in staffing.

11. The organizational relationship of the project to necessary ancillary and support services.

Virginia Beach General, DePaul and CHKD all are full service acute care hospitals. Virginia Beach General, a designated trauma center and a provider of open heart surgery services, seeks to add capacity to an existing surgical suite; the ORs it has proposed would be proximally situated to existing ancillary and support services. With respect to both of the proposed projects, all significant ancillary and support services are present within the respective applicant's organization and can be readily employed as needed.

12. The relationship of the project to the clinical needs of health professional training programs in the area in which the project is proposed.

Not applicable.

13. The special needs and circumstances of an applicant for a certificate, such as a medical school, hospital, multidisciplinary clinic, specialty center or regional health service provider, if a substantial portion of the applicant's services or resources or both is provided to individuals not residing in the health service area in which the project is to be located.

Not applicable.

14. The special needs and circumstances of health maintenance organizations. When considering the special needs and circumstances of health maintenance organizations, the Commissioner may grant a certificate for a project if the Commissioner finds that the project is needed by the enrolled or reasonably anticipated new members of the health maintenance organization or the beds or services to be provided are not available from providers which are not health maintenance organizations or from other health maintenance organizations in a reasonable and cost-effective manner.

Not applicable.

15. The special needs and circumstances for biomedical and behavioral research projects which are designed to meet a national need and for which local conditions offer special advantages.

Not applicable.

16. In the case of a construction project, the costs and benefits of the proposed construction.

The total capital costs of the DePaul-CHKD project would be $2,957,725 and would involve 23,453 square feet of leasehold improvements. The total capital costs of the Virginia Beach General project would be $1,540,798 and would involve construction of a 2,902-square foot addition at the rear of the hospital.

The total capital cost of the Virginia Beach General project amounts to $770,399 per general purpose OR. The total cost of the DePaul-CHKD project amounts to just $739,431 per general purpose OR. EVHSA notes, however, that this comparatively lower cost is misleading because DePaul-CHKD would lease space in the OSH, rather than purchase it. For the first five years of operation, EVHSA estimates that the total costs of the DePaul-CHK project would be substantially more than the capital cost of its first application, submitted in 1997, to establish an OSH in Virginia Beach, and asserts that this cost "would ultimately have to be paid in its entirety by the public."

17. The probable impact of the project on the costs of and charges for providing health services by the applicant for a certificate and on the costs and charges to the public for providing health services by other persons in the area.

EVHSA believes the OSH proposed by DePaul-CHKD cannot achieve its utilization projections without drawing patients from existing area hospitals, notably, Chesapeake General and the Sentara hospitals serving Virginia Beach. If so, establishment of the OSH would increase costs and, potentially, charges for surgical services in PD 20 by decreasing utilization at existing hospitals and OSHs. Regardless, the construction of the OSH involves costs that must be absorbed, and its implementation would necessarily involve the shifting of the Virginia Beach patients of DePaul-CHKD to the OSH. This shifting may result in an increase in the cost of outpatient procedures that remain at DePaul Medical Center and, perhaps more notably, CHKD, which would not relocate any ORs but would maintain existing surgical overhead costs.

Virginia Beach General's proposed project should not increase costs and charges for surgical services at other facilities since it does not threaten the capture of other facilities' patients. Despite the capital costs it involves, which also must be absorbed, the Virginia Beach General project offers the potential of reduced surgical costs, by spreading indirect and overhead costs over a larger, more productive base of surgical capacity, and by removing any inefficiencies associated with the prevailing overutilization and the extended hours of operation and staffing, and delay in scheduling that condition entails.

18. Improvements or innovations in the financing and delivery of health services which foster competition and serve to promote quality assurance and cost effectiveness.

Both Virginia Beach General and DePaul-CHKD contend that their proposals would offer benefits under this consideration. Virginia Beach General argues that its project would improve the delivery of surgical services by providing needed capacity, which would, in turn, promote quality assurance and cost effectiveness. DePaul-CHKD argues that its proposed OSH would improve delivery of services by addressing a "maldistribution" of ORs in PD 20 and would bring beneficial competition to Virginia Beach.

19. In the case of health services or facilities proposed to be provided, the efficiency and appropriateness of the use of existing services and facilities in the area similar to those proposed, including, in the case of rural localities, any distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care.

EVHSA has collected data showing that, based on the 1600-hour-per-year standard applicable to ORs, in 1999 the hospitals in PD 20 experienced an overall utilization rate of 101 percent of their general purpose ORs, and that, in the same year, the four OSHs in PD 20 experienced an overall utilization rate of 57.2 percent. Further, Virginia Beach General's general purpose ORs operated at a rate of 132 percent of this standard and its outpatient ORs operated at a rate of almost 107 percent. Both DePaul Medical Center and CHKD experienced low utilization – 58 and 69 percent, respectively.

20. The need and the availability in the health service area for osteopathic and allopathic services and facilities and the impact on existing and proposed institutional training programs for doctors of osteopathy and medicine at the student, internship, and residency training levels.

Not applicable.

III. RECOMMENDATION

I have reviewed the applications and subsequent submissions of Bon Secours-DePaul Medical Center and Children's Hospital of the King's Daughters (CHKD), on one hand, and Sentara Virginia Beach General Hospital, on the other. I have heard from counsel to the applicants in support of their respective applications, from counsel to Chesapeake General Hospital, which demonstrated good cause to be a party to the IFFC, and from the staff of the Division of Certificate of Public Need who evaluated the proposal. I have heard from the executive director of the Eastern Virginia Health Systems Agency (EVHSA) and have considered the recommendation issued by its board of directors.

Based on my assessment, I have concluded (i) that the Virginia Beach General proposal merits approval and should receive a certificate of public need (COPN), and (ii) that the DePaul-CHKD does not merit approval and should be denied.

The specific reasons for my recommendation include those discussed above, notably:

(i) The EVHSA recommended that the project proposed by Virginia Beach General be approved and the project proposed by DePaul-CHKD be denied;

(ii) Despite a seven percent surplus of ORs in PD 20, the ORs at Virginia Beach General have for several years experienced a utilization rate considerably in excess of

the applicable standard, demonstrating an institutional need for additional surgical capacity at that facility;

(iii) The relocation of ORs proposed by DePaul-CHKD is not necessary, as no problems relating to access, availability, distribution or general need exist, and further, promoting the convenience to health care providers and patients without due consideration of cost, the effect on other facilities, and the myriad principles of sound health planning is not the goal of the COPN law or the SMFP;

(iv) Approval of the relocation proposed by DePaul-CHKD would introduce negative competition into the Virginia Beach area, and may increase costs at DePaul Medical Center, CHKD, and other facilities;

(v) The costs of the project proposed by Virginia Beach General are reasonable, and no less costly and more effective alternative to the addition of two ORs to that hospital's surgical suite exists;

(vi) The outpatient surgery center proposed by DePaul-CHKD cannot achieve its utilization projections without drawing patients from existing area hospitals;

(vii) The Virginia Beach General project offers the potential of reduced surgical costs as efficiencies accrue from the rationalization of its surgical resources to existing and anticipated institutional need; and

(viii) The COPN program is not designed to impede successful facilities in their efforts to care effectively for current and anticipated patients.

In addition, I recommend that, to whatever extent may be necessary, the Commissioner affirm and restate her decision, made on June 5, 2001, finding that Chesapeake General Hospital had demonstrated good cause to be a party to the IFFC. This finding was announced to the parties at the IFFC on June 6, 2001, and is clearly warranted by facts and consideration of pertinent points of discussion throughout this recommendation.

Respectfully submitted,

Douglas R. Harris, J.D.
Adjudication Officer